THE UNION EXPERIENCE WITH HEALTH MAINTENANCE ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS*

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A Taft-Hartley trust fund, by law, is a fund which is jointly managed by representatives of both labor and management. Within the framework of the Taft-Hartley law, there are two kinds of trust funds: single-employer plans, which are collectively bargained between a union and one employer, and multiemployer plans, which are collectively bargained between a union and a group of employers, usually within a single industry. What these trust funds obviously have in common is that they result from union/employer collective bargaining to provide benefits for members/employees.

My background is in this field, specifically multiemployer, Taft-Hartley trust funds, for both health and welfare as well as pension plans. Multiemployer Taft-Hartley health and welfare trust funds currently number approximately 4,000 and cover more than 20 million employees and their dependents. Along with single-employer Taft-Hartley trust funds, they are a substantial market not fully appreciated by the health care industry.

As the health care industry finds that it can no longer afford to overlook the Taft-Hartley trust fund market, inroads are being made by innovative and aggressive health care providers through health maintenance organizations and preferred provider organizations. These organizations have the most to offer in the way of innovation and alternatives that best meet the somewhat unique requirements of Taft-Hartley trust funds. I shall try to offer my perspective on what those needs are and how HMOs and PPOs are suited or not suited to satisfy those needs.

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Something which seems fairly clear thus far is that Taft-Hartley trust funds generally have kept their distance from HMOs while gravitating toward PPOs. The reasons are far reaching, and many are indigenous to the current nature of the HMO. Yet HMOs have, in my opinion, the potential greatly to broaden their appeal to this market. Let us first look at the needs of Taft-Hartley funds.

To start, these funds, like any other health care purchaser in the country, are committed to cost containment. The degree of commitment can vary, but it is there. At the same time they have less flexibility than an employer-established plan in imposing many cost containment techniques. As stated, Taft-Hartley trust funds provide benefits that are collectively bargained. No one person or group can unilaterally decide on a plan change. Then, how will a plan change happen if the insured population might view it as a reduction or limitation in coverage? Obviously, the goal of the union is always to maintain, if not increase, coverage.

Many cost containment options practical for most health care purchasers may not be viable options for Taft-Hartley trust fund administrators who in their recommendations to the fund's trustees must reconcile the financial needs of the employers to spend less money with the union's goal of providing the highest level of benefits for their participants. Therefore, such traditional cost containment techniques as increasing deductibles and coinsurance levels and premium sharing may be neither viable nor desirable options for these administrators. Any reduction of benefits or, more important, anything that is perceived by the participants as a reduction of benefits, is often labeled a "give back." Therefore, it is the task of the Taft-Hartley fund administrator to encourage the maintenance and, where possible, the enhancement of benefits, while containing costs.

The solution to this enigma of maintaining or increasing coverage but not costs in many cases can involve HMOs and PPOs. So far, PPOs have more successfully exploited these needs.

Now for some historical perspective. While a common perception is that HMOs have been around longer than PPOs and that PPOs are a relatively new concept, the exact opposite is true from the perspective of those involved with Taft-Hartley trust funds. Unions, which have always wanted to provide quality health care for fewer dollars, have for many years organized their own panels of "preferred" providers. By using these providers, participants were covered in full, and avoided out-of-pocket expenses. These panels ranged from the simple to the complex and included physicians,

laboratories, hospitals, opticians, dentists and pharmacies. Many of the funds that the Amalgamated Life Insurance Company administers or serves work with unions that have health centers.

And then there is the best known and perhaps least recognized PPO of all: Blue Cross and Blue Shield. What more is Blue Cross/Blue Shield than large panels of providers who agree, in many cases, to discounted fees in return for volume. This concept originally appealed to unions and gave rise to the long-standing relationshihp between unions and the Blues. So the concept of a preferred provider organization is anything but new to Taft-Hartley trust funds.

An important and commonly known distinction between PPOs and HMOs is that PPOs offer freedom of choice in obtaining health care. This has weighed heavily for PPOs with Taft-Hartley trust funds. With a PPO, the participant is free to use any physician or facility he chooses—either one who participates in the PPO or not. Of course, if the participant chooses not to use a preferred provider, then that participant will not avail himself of the advantages negotiated between the fund, the PPO and the preferred provider. But the participant will not sacrifice all his benefits as is the case with an HMO. If a participant chooses a treating physician who is not a preferred provider, the participant will pay any charges over the schedule, about 20%, out-of-pocket, or he will not have a copayment waived—but that is the participant's choice.

The key element here is choice, and that has simply not been available with an HMO. This may be the biggest single disadvantage of HMOs because limits on the participant's freedom of choice are viewed to be as much a "give back" as a reduction in benefits.

So, with a PPO, Taft-Hartley trust funds can have it both ways: they can avail themselves of the same strong utilization controls that HMOs have, and at the same time their participants are not "locked into" a group of providers. It appears, however, that HMOs are now attempting to remedy this with flexibility by converting their already existing panels of cost-conscious providers to PPOs.

Another reason why Taft-Hartley trust funds prefer the PPO arrangement is that PPOs permit the fund to maintain a high level of visibility among its participants. Remember, unions are political organizations, whose leaders depend on the votes of their constituents. The health and welfare program, managed through the Taft-Hartley trust fund that the union negotiated, is a very tangible and constant reminder of what the union has accomplished. And, unlike HMOs, PPOs permit the fund office to handle such high visi-

bility functions as participant eligibility, plan communications and inquiries. The PPO does not stand between the fund and its participants, which is perceived to be the case with an HMO. Again, after HMOs become aware of this it is clearly within their means to eliminate this important but largely nonsubstantive impediment. The HMO wants customers, not credit, and to insist on both may result in neither when dealing with Taft-Hartley funds.

In addition, in many PPO situations claims processing remains a responsibility of the fund. This yields a twofold advantage to the fund. First, it does not diminish the fund's visibility among participants because claim forms are sent directly to and participant inquiries are handled directly by the fund's administrator. Second, many fund's administrators can process their participants' claims better and more cheaply than through a PPO. Needless to say, neither of these advantages is available through an HMO.

Another area where PPOs are more favorable, particularly to larger multiemployer Taft-Hartley trust funds, deals with the issue of who is at risk. Many multiemployer funds, the larger ones especially, want extensive utilization controls, but do not want to pay for risk protection. PPOs offer many of the same utilization control features as HMOs and at a reasonable cost. This presents the advantage of limiting and controlling a group's utilization without linking such control to unnecessary charges for risk protection. As the fund retains the risk, any decrease in utilization is directly and immediately experienced by the fund as decreased claims expense.

For many Taft-Hartley trust funds, an HMO can never result in savings. That is because these funds frequently provide varying levels of coverage, often convoluted by the exigencies of collective bargaining. With an HMO, which is usually locked into one or two comprehensive programs, the fund is faced with the dilemma of either providing HMO coverage at annual premiums, which may be greater than what the fund is accustomed to and capable of affording, or foregoing utilization control. This is not an infrequent situation because HMOs in general, and federally qualified HMOs in particular, provide a richer package of coverage than is available under most Taft-Hartley trust funds, particularly multiemployer funds.

The participant could bear the difference where the HMO's premiums and the fund's HMO contribution rates are out of line but that may be prohibitively expensive. This situation could never happen with a PPO as payments are made on an ongoing fee-for-service basis or at a capitation rate adjusted to the fund's benefit structure.

So, although Taft-Hartley trust funds have the same reasons as any other purchaser of health care to offer benefits through HMOs and PPOs, the

unique characteristics and needs of these trust funds create added incentives to go the PPO route. And it is safe to say that there is little likelihood of any significant inroads into the Taft-Hartley trust fund market for those HMOs that persist in keeping the same formula they have used for so long.

But HMOs are beginning to find the way to offer more attractive products—products sufficiently flexible to accommodate the unique concerns of Taft-Hartley trust funds. First, many HMOs are getting into the PPO business. The transition from an HMO, particularly an Individual Practice Association, or IPA-HMO, entails more of a change in the flow of paper work and money than any substantive change in structure. Short of marketing a full-blown PPO, many HMOs are beginning to make available the kinds of cost containment services that Taft-Hartley trust funds want and that HMOs are prepared to administer. A Taft-Hartley trust fund not interested in offering an HMO option to its participants may nonetheless be interested in purchasing from an HMO such services as second surgical opinions, hospital preadmission certification, concurrent hospital utilization review and discharge planning. However, while the Taft-Hartley trust fund market offers great promise to HMOs, and especially to PPOs, there can be significant differences that, in some cases, can make an HMO or PPO offering difficult if not impossible.

The first and most obvious difference that comes to mind deals with single employer versus multiemployer plans. On the one hand, a single employer plan is, by and large, comprised of a homogenous group of participants. By this I mean that participants usually are the same sex, fall within the same age group, have relatively similar incomes and often speak one language. Moreover, in most cases, participants reside in the same area. The bottom line here is that the utilization of health care services, in terms of extent, frequency, kind and cost, is relatively similar and therefore predictable for the entire group.

On the other hand, a large proportion of, but by no means all, multiemployer plans tend to be heterogeneous. That is, some employers may employ mostly male employees, while other contributing employers may have a largely female work force. The average age and income of the participants may vary, too, from employer to employer or on a regional basis. Moreover, the population may be either concentrated in a single area or region or be national in distribution. Last, educational levels and languages may vary—a very important factor and the key element of cost containment education. With a multiemployer plan, therefore, utilization can vary from region to region or even from employer to employer. So the need to contain costs and what programs are applicable can similarly vary.

The distribution of participants also has another impact on the feasibility of an HMO or PPO. Groups concentrated in well-defined, urban areas are, for purely practical reasons, much easier to fit into an HMO or PPO. Participating physicians, hospitals and other providers are easily accessible to participants, ideally they are in the same neighborhood. However, the opposite tends to be true for groups spread out across rural areas, as participants often must travel considerable distances in order to utilize participating providers. The result is that HMOs and PPOs are often effective for urban groups for the same reason that they can fail for rural groups: the ratio of participants to providers.

A separate factor that deserves attention is the level of benefits available. Taft-Hartley trust funds associated with financially stable industries usually offer a rich, major medical coverage. The higher the level of benefits, the easier to accommodate an HMO or PPO. On the other hand, funds associated with low paying or declining industries generally have cash indemnity coverages, comprised of a patchwork of fixed schedules of payments. The idea here is that, unless the HMO or PPO is sufficiently flexible in terms of which programs it can offer, there is little likelihood that any "fit" can be worked out with these funds.

With regard to PPOs, another point is to be made: PPOs represent less savings to funds with low, fixed cash indemnity payments because there is less fat to be cut off. In fact, it is possible, where benefit levels are very low, for a PPO actually to result in a cost rather than savings to a fund. This could happen where PPO savings are offset by the cost of the incentives to use the PPO—such as decreased or waived deductibles and coinsurance factors, plus the administrative expense of implementing the PPO.

Another area that influences a decision for or against HMOs or PPOs, and that applies equally to all Taft-Hartley trust funds, whether single or multiemployer, is the fund's ability to generate data about its group. For example, a PPO must be assured that only eligible participants are referred to their participating providers. For this, they usually require monthly or quarterly prospective eligibility reports from their client funds. However, some funds, due either to their lack of sophistication or the peculiarities of the industry it serves, may not be equipped to generate such reports. Similarly, the fund must be able to analyze the PPOs' billing to verify that payments are only for covered services for eligible participants. In the case of an HMO, the fund must verify that premium payments to the HMO are for eligible participants. Further, and perhaps more important, the fund must be able to track utilization for both its HMO/PPO and non-HMO/PPO related expenses to determine how much savings, if any, have resulted.

Blue Cross plans have their own peculiar impact on HMO/PPO development. I say peculiar because, as in most of their activities, what the Blues can and cannot do varies from Blues plan to Blues plan, but there is a common thread—Blue Cross plans in the old industralized urban areas, such as New York or Philadelphia, generally offer good hospital discounts, ranging as high as 30%, and most competing HMOs and PPOs would be hard put to top this, and most Taft-Hartley trust funds which have contracts with these Blues plans would be reluctant to lose these discounts. However, Blues plans in the less industralized states or the more recently industralized states generally have little or no discounts for hospital bills, so the funds may do better by paying hospital claims through an HMO or PPO which has contractual discounts.

Another point about the Blues needs to be made: most Blue Cross and Blue Shield plans have in place or are in the process of implementing their own HMO and PPO packages. And many of the Blues are now offering the type of utilization controls such as hospital precertification, concurrent utilization review and discharge planning that were once available only through HMOs and PPOs.

Last, there is communication, which has a special significance for Taft-Hartley trust funds. Not only does visibility play a role here, but also sensitivity, as it is the fund's administrator and his staff which are the most knowledgeable and best equipped to deal with the idiosyncracies of their group. Therefore, the PPO or the HMO providing cost control services should allow for the option of having educational meetings, written communications and all telephone communications handled exclusively by fund personnel. This also streamlines communications between the fund and its participants because all inquiries are directed to the same office.

Above all, it is absolutely necessary that any program, whether an HMO or a PPO, be understood by all the fund's participants; any confusion among participants as to benefits and procedures could result in, at best, embarassment, and possibly additional costs, to the fund.

So, while this market, by virtue of the unique characteristics and needs of Taft-Hartley trust funds, poses a seemingly formidable challenge, HMOs and PPOs already possess the key to unlock the market—cost containment, good benefits and quality care. The ultimate winners will be those HMOs and PPOs that exercise the knowledge and the flexibility and willingness to fit the key into the lock.